ABSTRACT

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EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE: ATTITUDES AND BELIEFS AMONG COLLEGE AGE STUDENTS

Advisor: Dr. Clark White

Thesis dated July, 2000

This study examined the attitudes and beliefs of college age students about euthanasia and physician assisted suicide.

It compared the attitudes of college students at Clark Atlanta University and Georgia State University and how those differed from other groups. It assumed that race, age, and gender would have an impact on the attitudes and beliefs of college students concerning euthanasia, physician assisted suicide, and a terminal illness.

The approach used to gather this information was to distribute a questionnaire to Clark Atlanta University and Georgia State University students in the Atlanta area.

The findings revealed that the majority of students were in favor of euthanasia and physician assisted suicide and thought these practices should be legalized.

The conclusions drawn from this study suggest that race, age, and gender do have an influence on attitudes and

physician assisted suicide. These students support the legalization of euthanasia and physician assisted suicide. A significant majority of them thought they should have the right to do so if they themselves had a terminal illness.

# EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE: ATTITUDES AND BELIEFS AMONG COLLEGE AGE STUDENTS

A THESIS

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THE DEGREE OF MASTER OF ARTS

BY

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CLARK ATLANTA UNIVERSITY THESIS OR DISSERTATION

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## CHAPTER ONE

## PURPOSE AND RATIONALE

The purpose of this study is to examine the attitudes of college students about euthanasia and physician assisted suicide. It also examines the question of legalization of euthanasia as it concerns college students. This study compared attitudes of individuals who have been previously studied, and how those differ with college students. Do these thoughts, values and attitudes clash? There has been controversy and public interest over the implementation of euthanasia and physician assisted suicide. There is an ongoing debate about its legalization. Little is known about the attitudes of college students toward euthanasia and physician assisted suicide for the terminally ill. What factors if any, would effect their attitudes? Would they be based on persons with HIV/AIDS, elderly persons, people with cancer and other terminal illnesses, or would those factors not have any effect on their attitudes about euthanasia and physician assisted suicide.

Previous research demonstrates that these variables are related to people's attitudes toward euthanasia and

physician assisted suicide.[1] When we look at Domino's study, it also supports a relationship to the variables.[2] Holloway's study, agrees that the variables race, age, and gender effected people's general attitudes toward euthanasia and physician assisted suicide.[3] This study will replicate previous research in testing this relationship of attitudes toward euthanasia and physician assisted suicide based on race, age, and gender. This study was intended to provide further insight into the thoughts and attitudes of the next generation and what that means for policy changes concerning the legalization of euthanasia and physician assisted suicide.

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[1]B. K. Singh, "Correlates of Attitudes Toward Euthanasia," *Social Biology*, 26 (1977), 247-253.

[2]George Domino, "Physician Assisted Suicide: A Scale and Some Empirical Findings," *Omega*, 34 (1996-97), 247-257.

[3]Harold Holloway, "Measuring Attitudes Toward Euthanasia," *Omega*, 30 (1994-95), 53-65.

## CHAPTER TWO

## PREVIOUS RESEARCH

A literature review showed that there was a relationship between euthanasia and physician assisted suicide and race, age, and gender. However, many studies differed in their operational measures associated with evaluating attitudes about euthanasia and physician assisted suicide. Included were measuring attitudes toward euthanasia such as in Holloway's study which asked a series of questions in which the respondents answered with strongly agree, agree, no opinion, disagree, strongly disagree.[1] In Domino's study, the responses to beliefs and attitudes about physician assisted suicide were agree, disagree, not sure.[2]

### Attitudes Based on Race

Singh found that Blacks were least likely to approve of euthanasia and suicide than Whites. Whites approved of euthanasia 65.4 percent versus Blacks who approved of euthanasia 39.4 percent. In 1994, the Harris

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[1]Harold Holloway, "Measuring Attitudes Toward Euthanasia," *Omega*, 30 (1994-55), 53-65.

[2]George Domino, "Physician Assisted Suicide: A Scale and Some Empirical Findings," *Omega*, 34 (1996-94), 247-257.

Poll indicated that 73 percent of Anglos, 65 percent Hispanics, and 53 percent of Blacks favored a law allowing a doctor to comply with the wishes of a suffering dying patient who "asks to have his or her life ended."[3] Another study by Mebane was to determine whether physicians preferences for end-of-life decision-making differ between Black and Whites in the same pattern as patient preferences, with Blacks being more likely than Whites to prefer life-prolonging treatments.[4] Several studies examining racial differences in patient preferences for end-of-life treatments and physician assisted suicide report that Black patients tend to request more life-sustaining treatments than their White counterparts. Black patients also tend to view physician assisted suicide more negatively and to place a higher value on longevity than White patients. Results from Mebane's study showed that 502 physicians (28%) who returned the questionnaire included 280 Whites and 157 Black physicians. With regard to attitudes toward patient care, 58% of White physicians agreed that tube-feeding in terminally ill patients is "heroic," but only 28% of Black physicians agreed with the statement ($p<.001$). White

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[3]Elizabeth Morrow, "Attitudes of Women from Vulnerable Populations Toward Physician-Assisted Death: A Qualitative Approach," *Journal of Clinical Ethics*, 8 (1997), 279-288.

[4]Eric Mebane, "The Influence of Physician Race, Age, and Gender on Physician Attitudes Toward Advance Care Directives and Preferences for End-of-Life Decision-Making," *Jags*, 47 (1999), 579-591.

physicians were more likely than Black physicians to find physician assisted suicide an acceptable treatment alternative (36.6% versus 26.5% of Black physicians) ($p<.05$). Physicians preferences for end-of-life treatment follow the same pattern by race as patient preferences, making it unlikely that low socioeconomic status or lack of familiarity with treatments account for the difference. Self-denoted race may be a surrogate marker for other, as yet undefined factors. In Eskimo cultures according to Hoefler, old or sick individuals are allowed to petition for euthanasia by telling their families they are ready to die, and they honor their wish and send them off on the journey on "mother ice," where the individual is abandoned.[5] In a study by Domino the study showed that 52% of Chinese felt that people have a right to die when those wishes are expressed versus "other" races with 42%. To the statement "people with incurable diseases should be allowed to commit suicide in a dignified manner" almost half (46%) of the Chinese agreed. To the statement "suicide is an acceptable means to end an incurable illness," (67%) of Chinese agreed.[6]

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[5]James Hoefler, *Death Right: Culture, Medicine, Politics, and the Right to Die* (San Francisco: Westview Press, 1994).

[6]George Domino, "Attitudes Toward Suicide and Conservatism: A Comparison of Chinese and United States Samples," *Omega*, 31 (1995), 237-252.

**Age as a Factor for Attitudes About Euthanasia and Physician Assisted Suicide**

According to Klopfer's study, euthanasia has become a concept associated with the young as well as the old. Since the rise of Humanism and the recent emphasis on care and treatment of terminally ill persons, euthanasia also becomes a more acceptable alternative to unwarranted suffering. In Klopfer's study, it is the assumption that the duration of the dying process is an important consideration in euthanasia acceptance and will be directly related to the age of the person. The respondent's age will also be examined in relation to his preference for a slow or sudden death. The method of data analysis chosen to access relationships was chi square. The respondents whose data constituted the first set were significantly older (chi square=4.513, df= 1, $p<.05$). The relationship of respondent's age to his preference for sudden death was not indicated as being reliable, although a significant inverse relationship exists between euthanasia acceptance and respondent's age; younger persons in the sample were significantly more approving of euthanasia ($p<.01$). It was predicted that a slow death would be preferred by older persons. This assumption was not verified by the data. The assumption that euthanasia acceptance would be directly related to age was not confirmed. Instead a significant

inverse relationship existed.[7] In Morrow's study, it was shown in a December 1994 Harris poll that 76 percent of persons aged 25 to 27 were in favor of the law allowing a doctor to comply with the wishes of a suffering dying patient who asks "to have his or her life ended," as compared to 64 percent of those over 65.[8] Yet in Domino's study, of a Gallup poll, the results of telephone interviews with a sample of 802 adults aged sixty years and older. Responses to five items were analyzed but only one item referred to physician assisted suicide, namely "the laws should allow physicians to assist senior citizens in committing suicide in cases where a person has been diagnosed with an incurable disease and is suffering from severe unrelenting suffering." Of the respondents, 23 percent indicated that they strongly disagreed with the statement, 22 percent disagreed, 26 percent agreed and 15 percent strongly agreed, with 14 percent not knowing.[9] In Hoefler's study, nearly one-third of all right-to-die cases heard to date (34 out of 108) have involved patients seventy years or older. More right-to-die patients are in their

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[7]Ibid., 250.

[8]Elizabeth Morrow, "Attitudes of Women from Vulnerable Populations Toward Physician-Assisted Death: A Qualitative Approach," *Journal of Clinical Ethics*, 8 (1997), 279-288.

[9]George Domino, "Physician Assisted Suicide: A Scale and Some Empirical Findings," *Omega*, 34(1996-97), 247-257.

seventies than in any other ten year age bracket.[10] According to Gay's book, the largest group of Americans who want to determine for themselves how they will die are the elderly.[11] But again in Singh's study, persons aged between 35 to 44 approved of euthanasia 60.2% yet when it came to physician assisted suicide it was 36.3%. Persons aged 45 to 54 approved of euthanasia 60.6% not far off the 35 to 44 group and with physician assisted suicide it was 38.1%. Persons aged 55 to 64 approved of euthanasia 58.5% and physician assisted suicide 30.0%. 65 + age approved of euthanasia 53.5% and physician assisted suicide 27.7%.[12]

## Attitudes Toward Euthanasia and Physician Assisted Suicide in Relation to Gender

Morrow's study found that 74 percent of men versus 67 percent of women supported a law allowing a doctor to comply with the wishes of a suffering dying patient who asks "to have his or her life ended."[13] In Singh's study, the purpose of the research is to examine patterns of approval

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[10]James Hoefler, *Death Right: Culture, Medicine, Politics, and the Right to Die* (San Francisco: Westview Press, 1994).

[11]Kathlyn Gay, *The Right to Die* (Connecticut: The Millbrook Press, 1993).

[12]B. K. Singh, "Correlates of Attitudes Toward Euthanasia," *Social Biology*, 26 (1977), 247-253.

[13]Elizabeth Morrow, "Attitudes of Women from Vulnerable Populations Toward Physician-Assisted Death: A Qualitative Approach," *Journal of Clinical Ethics*, 8 (1997), 279-288.

and disapproval of euthanasia and suicide for terminally ill persons. Results showed there were wide variations between males and females on the issue of euthanasia as well as suicide. Females were less likely to approve of euthanasia and suicide. Males who approved of euthanasia was 67.5 percent as opposed to females 58.1 percent.[14] The extent to which one approved of suicide for persons with an incurable disease was also likely to be predictive of one's attitudes toward euthanasia. In Sugarman's study, the results showed that women evaluated the physician and his action of some form of euthanasia as morally positive. Women at (M=2.89) than men (M=3.28), significant results ($F(1,600)<1.00$, p=ns). Effect, (Wilks lambda=.980, $F(3,598)=4.04$, $p<.007$).[15]

**Race and Attitudes**

The study of the independent variable, attitudes based on race was supported in several research studies. In Singh's it was shown that Blacks and Whites differed in their attitudes on euthanasia and physician assisted suicide with chi square results significant at the 0.05 level for

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[14]B. K. Singh, "Correlates of Attitudes Toward Euthanasia," *Social Biology*, 26 (1977), 247-253.

[15]David Sugarman, "Active versus Passive Euthanasia: An Attributioinal Analysis," *Journal of Applied Social Psychology*, 16(1986), 60-76.

the variables indicated for euthanasia, with Whites approving 65.4 percent and for suicide 42.0 percent. Yet for Blacks 39.4 percent approving of euthanasia and 20.6 percent for suicide.[16] As we saw in Morrow's study concerning race, the highest group approving of this was Anglos 76 percent compared to 53 percent of Blacks who approved.[17] Mebane included Black and White patients as well as physicians attitudes toward end-of-life decision-making. Out of 502 physicians, White physicians were more likely than Black physicians to find physician assisted suicide an acceptable treatment alternative (36.6 percent versus 26.5 percent of Black physicians) ($p<.05$).[18] Yet in other studies such as Hoefler[19], Eskimo's approve of and practice euthanasia. In Domino's study, Chinese people approve of right-to-die if it is an end to suffering from an incurable illness.[20]

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[16]B. K. Singh, "Correlates of Attitudes Toward Euthanasia," *Social Biology*, 26 (1977), 247-253.

[17]Elizabeth Morrow, "Attitudes of Women from Vulnerable Populations Toward Physician-Assisted Death: A Qualitative Approach," *Journal of Clinical Ethics*, 8 (1997), 279-288.

[18]Eric Mebane, "The Influence of Physician Race, Age, and Gender on Physician Attitudes Toward Advance Care Directives and Preferences for End-of-Life Decision-Making," *Jags*, 47(1999), 579-591.

[19]James Hoefler, *Death Right: Culture, Medicine, Politics, and the Right to Die* (San Francisco: Westview Press, 1994).

[20]George Domino, "Physician Assisted Suicide: A Scale and Some Empirical Findings," *Omega*, 31(1996-97), 237-252.

## Age and Attitudes

The study of the independent variable age was supported in several research studies. Klopfer's results of this study, indicated that the relationship of respondents age to his preference for sudden death was not indicated as being reliable.[21] Although a significant inverse relationship exists between euthanasia acceptance and respondent's age; younger persons in the sample were significantly more approving of euthanasia ($p<.01$). For the Chi square values the age of the respondent towards euthanasia acceptance was 8.091 ($p<.01$) df=1. Yet in Domino's study,[22] it was shown that adults sixty years and older agreed that laws should allow physicians to assist senior citizens in committing suicide in cases where they are suffering from an incurable disease.

## Gender and Attitudes

The study of the independent variable, attitudes based on gender was supported in several research studies. In Morrow's study,[23] it was shown that 74 percent of men

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[21]Frederick Klopfer, "Euthanasia Acceptance as Related to After Life Beliefs and Other Attitudes," *Omega*, 9 (1978-79), 245-253.

[22]George Domino, "Physician Assisted Suicide: A Scale and Some Empirical Findings," *Omega*, 34(1996-97), 247-257.

[23]Elizabeth Morrow, "Attitudes of Women from Vulnerable Populations Toward Physician-Assisted Death: A Qualitative Approach," *Journal of Clinical Ethics*, 8 (1997), 279-288.

versus 67 percent of women supported a law allowing a doctor to comply with the wishes of a suffering dying patient who asks "to have his or her life ended." In Singh's study,[24] the purpose of the research is to examine patterns of approval and disapproval of euthanasia and suicide for terminally ill persons. The results showed there were wide variations between males and females on the issue of euthanasia as well as suicide 67.5 percent and 58.1 percent respectively. Yet in Sugarman's study, women approved of the doctors actions taken to euthanasia than did men.[25]

**Attitudes Toward Legalization of Euthanasia and Physician Assisted Suicide**

In Mojica's study,[26] statistics complied by the Hemlock Society, incidences of all forms of euthanasia occurring in only the last eleven years, which includes mercy killing, assisted suicide, and auto-euthanasia, constitute more than 85% of all reported incidences of euthanasia. In a 1988 poll conducted by the Roper organization of New York, 58% of those surveyed stated that physicians should be allowed to assist a terminally ill

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[24]B. K. Singh, "Correlates of Attitudes Toward Euthanasia," *Social Biology*, 26 (1977), 247-253.

[25]David Sugarman, "Active versus Passive Euthanasia: An Attributioinal Analysis," *Journal of Applied Social Psychology*, 16(1986), 60-76.

[26]Stacy Mojica, "The Right to Choose - When Should Death be in the Individual's Hands?" *Whittier Law Review*, 12 (1991), 471-504.

patient to commit suicide without the threat of legal sanctions.[27] A number of states have enacted statutes prohibiting the aiding or abetting of a suicide. Nine states include the offense within the crime of manslaughter, requiring intentional, purposeful or knowing assistance of the suicide. According to Scher's study, euthanasia is equivalent to homicide in the United States. Yet, a survey conducted at a Chicago Medical Convention disclosed that 61% of the physicians present believed that euthanasia was being practiced by members of the profession.[28] Cohen's study found that acts that intentionally cause the death of a person or induce a person to take his or her own life are unlawful throughout the United States. A physician is prohibited from knowingly and directly causing death. Whether or not a state has an assisted-suicide statute, it has been difficult to use the criminal law against a physician.[29] In Whiting's study, over the last two decades, the debate on this important issue has grown in the United States at a steady rate. As a result numerous organizations have formed that advocate for the recognition of what has

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[27]Ibid., 486.

[28]Edward Scher, "Legal Aspects of Euthanasia," *Albany Law Review*, 36(1971-72), 674-697.

[29]Jonathan Cohen, "Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State," *The New England Journal of Medicine*, 331 (1994), 89-94.

popularly become known as "the right to die." Primary among these organizations is the Hemlock Society, with 160,000 members; the Society for the Right to Die, with 147,000 members; Concern for Dying, and the World Federation of Societies for the Right to Die, founded in 1980.[30] In Morris's study adults were interviewed and these are the results. Almost 60 percent of the 422 older adults feel that the terminally ill have the right to take their own lives to end suffering that results from a terminal illness, some 56 percent feel that Dr. Jack Kevorkian should not be prosecuted for his involvement in assisted suicide.[31] Teno's study showed that, a "weariness with life" may be a growing reason for requests of voluntary active euthanasia. By legalizing euthanasia, patients could choose the exact circumstances and time of their death.[32] Gifford's study goes on to say, this growing desire for "death with dignity" has sparked an international movement to legalize both passive and active euthanasia. In the United States, attempts to gain legal recognition of a patients right to request passive euthanasia methods, such as disconnection of

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[30]Raymond Whiting, "Natural Law and the 'Right to Die,'" *Omega*, 32 (1995-96), 11-26.

[31]David Morris, "Older Adults Perceptions of Dr. Jack Kevorkian in Middletown, U.S.A.," *Omega*, 35 (1997), 405-412.

[32]Joan Teno, "Voluntary Active Euthanasia: The Individual Case and Public Policy," *Jags*, 39 (1991), 826-829.

life support machinery and termination of medical treatment, have been largely successful. The debate over active euthanasia, that is, aid-in-dying by lethal injection or administration of barbiturates, has been far more bitter, and to date the practice is not legal anywhere in the world.[33]

The majority of older people in the United States have indicated that they support euthanasia and physician assisted suicide. Numerous polls taken have shown that those surveyed believe that physicians should be allowed to assist their terminally ill patients with suicide. The public has also shown support for Dr. Jack Kevorkian in his assisting people to die. Many older people feel that physician assisted suicide and euthanasia should be made legal and that physicians who assist at the present should not be prosecuted.

Due to such great debate and controversy over this issue, more and more people are joining and supporting right to die organization, and fighting for its legalization.

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[33]Eugenie Gifford, "Active Euthanasia and the Art of Dying," *UCLA Law Review*, 40(1993), 1545-1585.

## CHAPTER THREE

## CONCEPTUAL FRAMEWORK

The conceptual frameworks that most frequently appear in the literature on attitudes toward euthanasia and physician assisted suicide were as follows: Natural Law Theory; Kamisar's "Wedge Theory;" Model of Medical Power and Technology; Dogmatic Model; Durkheim's Theory of Suicide; The Slippery Slope Theory; and Modern Medical Model.

The conceptual frameworks presented share a strong degree of interconnectedness in relation to the relationship which have been established empirically. However, the conceptual frameworks that best apply to the independent variables in this study are Kamisar's "wedge" theory[1] and dogmatic model[2] and the slippery slope theory.[3] With the respect to the independent variable of race the Kamisar's "wedge" theory and the slippery slope theory supports this variable. These two theories support one another in that

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[1]Eugenie Gifford, "Active Euthanasia and the Art of Dying," *UCLA Law Review*, 40(1993), 1545-1585.

[2]Francis Degnin, "Levinas and the Hippocratic Oath: A Discussion of Physician Assisted Suicide," *The Journal of Medicine and Philosophy*, 22 (1997), 99-123.

[3]James Hoefler, *Death Right: Culture, Medicine, Politics, and the Right to Die* (San Francisco: Westview Press, 1994).

active euthanasia could get out of control to the point that the government could eliminate people and they would be euthanized against their will. With respect to the independent variable age, Durkheim's theory of suicide[4] and the slippery slope theory support this variable. According to the slippery slope theory, euthanasia could reach the point that older people would feel pressured to choose euthanasia so they will not be a burden to their family. Durkheim's theory applies because as people get older they lack the social integration and also there are social changes going on in their lives, such as the death of a spouse and friends. With respect to the independent variable gender, natural law theory and model of medical power and technology supports this variable. Men and women today are concerned with public policy, and things going on in the legal system. They are very aware of decisions concerning the "right to die" and how the government is going to address this issue. The model of medical power[5] and technology is especially important in today's society. With people being more health conscious, they may interpret (as physicians do) that the body is a machine and it is

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[4]Robert Weir, *Physician-Assisted Suicide* (Indiana: Indiana University Press, 1997).

[5]Ibid., 208.

important that it works well for them and when it does not they seek physicians expertise.

The **Natural Law Theory** has been a strong medium of change throughout the history of Western civilization. Natural law theories transformed loose philosophical thought into the legal system that ruled the Roman empire. As natural law theories are traced through history, they lead directly to the United States where a uniquely American interpretation became one of the foundational principles for our constitution. By applying these theories to the contemporary question of the "right to die," natural law can again provide the foundational principles needed to develop standards for dealing with such questions that are consistent with our historical, philosophical, and political traditions.[6] This is of importance to those who seek guidance in making public policy decisions concerning the "right to die," because it is this Americanized doctrine of natural law or natural rights that has served as the foundation of most of our government and so may serve equally well as a platform upon which to construct a coherent policy concerning the "right to die" according to Whiting.[7]

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[6]Raymond Whiting, "Natural Law and the 'Right to Die,'" *Omega*, 32 (1995-96), 11-26.

[7]Ibid., 18.

**Kamisar's "Wedge" Theory** is a variant of the slippery slope argument commonly appealed to when moral issues are debated. It suggests that once a rule of law is laid down which permits active euthanasia in certain narrowly defined circumstances, there will be no way to contain the practice, and ultimately, people will be "euthanized" against their will. As the argument goes, euthanasia could easily become a front for politically motivated government killings.[8]

According to the **Model of Medical Power and Technology** by Degnin, the body is understood primarily as a sophisticated and well-balanced machine, so that the purpose of medicine is to ensure that the machine works well for its occupant. This approach emphasizes the dogmatic tradition of medicine-diagnosis- where symptoms are understood as visible signs of invisible ailments, ailments which can then be grouped according to class. The uniqueness of the individual came to be understood in terms of one's variance from a range of "normal" physiological functions, so that the primary expertise of the medical professional is his/her

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[8]Eugenie Gifford, "Active Euthanasia and the Art of Dying," *UCLA Law Review*, 40(1993), 1545-1585.

ability to use the reports of the patient to place that patient within a diagnostic matrix.[9]

The **Dogmatic Model** assumes that the uniqueness of the individual is found in its variation from a "correct" whole-just as, from certain religious points of view, variation from "God's" "correct" plan is sin. In fact, it was the compatibility of the Hippocratic Oath with the tenets of Christianity which accounted for much of its general acceptance by the medical profession. But it must be clear that, in this model, the patient is not really the person who determines what would be his/her "benefit." Instead, it is medical, moral, and legal models to which the physician primarily attends.[10]

Views of **Durkheim's Theory of Suicide** in early Christianity suggest not only an ignorance of early Christian theology and history but also the conceptual influence of Durkheim. Durkheim created three categories of suicide that can be viewed as etiologically explicable with reference to social structures: (1) egoistic (resulting from a lack of social integration); (2) anomic (precipitated by the destabilizing effects of sudden negative or positive

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[9]Francis Degnin, "Levinas and the Hippocratic Oath: A Discussion of Physician Assisted Suicide," *The Journal of Medicine and Philosophy*, 22 (1997), 99-123.

[10]Ibid., 108.

social change); and (3) altruistic (resulting from over-integration, especially when the individual is completely controlled by religious or political groups).[11] According to Durkheim, dying for one's beliefs is suicide.[12]

In typical functionalist fashion, Durkheim bases his theory on social cohesion or solidarity and on two specific societal needs, integration and regulation. His hypothesis is that societies characterized by too much or too little integration or regulation will have high suicide rates.[13]

Anomic suicide, in which people suffer a sudden dislocation of normative systems where their norms and values are no longer relevant, so that controls of society no longer restrain them.[14] An example of this concept would be people with AIDS. Once a person or even a group of people discover that an individual has HIV/AIDS it changes the way that person is seen. Among all racial backgrounds, ages and gender this disease has preconceived notions of "who" gets HIV/AIDS. There is the stereotypical thought

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[11]Robert Weir, *Physician-Assisted Suicide* (Indiana: Indiana University Press, 1997).

[12]Ibid., 208.

[13]Ruth Wallace, *Contemporary Sociological Theory* (New Jersey: Prentice Hall, 1999).

[14]William Cockerham, *Medical Sociology* (New Jersey: Prentice Hall, 1998).

that if the person is a White male that he must be gay and that already has societal problems. If that individual is a Black male he must be a drug addict, although many Black communities deny an AIDS problem because of the meaning that comes with HIV/AIDS.

People that have HIV/AIDS are no longer seen as valued or productive members of society. They are shunned by family, friends, co-workers, and even their churches. Their "normal" life is no longer considered normal. Society does not want to see them or deal with them. The person with HIV/AIDS knows the end result is a horrible and very painful death. We as a society do not want to see death or talk about it. This is where Durkheim's theory comes into play. The person with HIV/AIDS is dislocated from the norms by societies' reaction to them, that the individual feels their life and values are no longer relevant to that society. Some HIV/AIDS patients have requested Physician Assisted Suicide so they won't be a burden to society, family and friends. For many, it is to rid themselves of the pain and the indignity of their dying process.

The **Slippery Slope Theory** is an important case made against assisted suicide on ethical grounds which involves the "wedge" or "slippery slope" argument. According to the line of thought, legitimizing mercy killing in any context

permits entry of a "wedge" that would inevitably lead to a complete breakdown in application, with euthanasia performed as a matter of convenience, without thought to the rights of the physically disabled, the old, the mentally infirm, and others. This would lead us down the "slippery slope": one step on the assisted suicide ramp would cause society to slide downward uncontrollably, to the point where euthanasia would be administered without consent in some cases and where potential candidates would feel pressured to choose the euthanasia option rather than burden family and friends by prolonging the inevitable.[15] According to Larue, this theory, once medically assisted euthanasia is legalized for the terminally ill who request it, legalized killing of other groups will automatically follow and even become compulsory.[16]

The **Modern Medical Model** is built upon the problems of illness and injury, and its beneficent goals include saving lives or prolonging them, restoration of function, and alleviation of physical distress. In addition to the beneficence principle of acting to the good of patients, the prevailing biomedical model includes the principles of nonmaleficence, autonomy, truth-telling, justice in the

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[15]James Hoefler, *Death Right: Culture, Medicine, Politics, and the Right to Die* (San Francisco: Westview Press, 1994).

[16]Gerald Larue, *Play God* (Rhode Island: Moyer Bell, 1996).

distribution of health care resources, and maintenance of professional standards of practice.[17]

[17]Robert Weir, *Physician-Assisted Suicide* (Indiana: Indiana University Press, 1997).

## CHAPTER FOUR

## DATA AND METHODS

The target population of this study were college students from Clark Atlanta University and Georgia State University. The best sampling design used for this particular population in this study was probability sampling. A sample in which each subject that could be chosen has a known probability of being sampled. The research tool to be used in this study will be the questionnaire. A sample of these questions to be used to generate the operational measures for each of the variables are as follows:

1. What is your race?

   -White -Black -Asian -other

2. What age group are you in?

   -(17-21) -(32+)

   -(22-26)

   -(27-31)

3. What is your gender (sex)?

   -Male -Female

4. Attitudes about euthanasia and physician assisted suicide for the terminally ill.

To me there is absolutely no justification for ending the lives of persons even though they are terminally ill.

Strongly agree-

Agree-

Disagree-

Strongly disagree-

Don't know-

These questions are likely to get maximum valid responses since they are closed-ended categories. The question for the dependent variable was extracted from Harold Holloway et al., *Measuring Attitudes Toward Euthanasia.* The question for the independent variable race was extracted from B. K. Singh, *The Correlates of Attitudes Toward Euthanasia.* The question for the independent variable age was extracted from Frederick Klopfer et al. *Euthanasia Acceptance as Related to After Life Belief and Other Attitudes.* The question for the independent variable gender was extracted from *Contributions of Health and Demographic Status to Death Anxiety and Attitudes Toward Voluntary Passive Euthanasia,* by Gerald Devins.

## CHAPTER FIVE

## DISCUSSION

Literature on race, age, and gender is expansive. As has been seen consistently throughout the literature, attitudes toward euthanasia and physician assisted suicide has not translated into knowledge pertaining to euthanasia and physician assisted suicide. Nevertheless, euthanasia and physician assisted suicide has become a serious issue in our society. Physicians and other health professionals who once were opposed, have become very divided on the issue. Surveys are showing that public opinion is very much in favor of allowing physicians to assist their patients who are terminally ill. However, patient interest groups are concerned with what the consequences could be if physician assisted suicide became legal. Groups that are at risk for abuse of this practice include, people with disabilities, people who are members of racial minorities, the elderly, women, and people who are not mentally competent. Arguments about the legalization of physician assisted suicide has touched all areas of people's lives. From political, where it has been brought all the way to the United States Supreme Court, to how people of various races, age, and gender feel

age, and gender feel about this debate. Therefore, this study can be a contribution to the understanding of the attitudes and beliefs of college students today since they are our next generation of policy and law makers. This is a very controversial issue and without additional efforts to study this population and their attitudes we will not have this issue resolved any time soon. Will this generation have the attitude that euthanasia should be legalized and if so, will there be stipulations of how or who will carry out the process of euthanasia and will doctors have to be specially licensed to perform physician assisted suicide? This is the goal of this study.

## CHAPTER SIX

## RESULTS

The study consisted of 116 subjects who participated in the present study by responding to a questionnaire. This questionnaire was a twenty-five point likert type response. Ninety-four females and twenty-two males, with one person not giving their gender.

Half the items were written in the affirmative (strongly agree or agree- pro euthanasia and physician assisted suicide) while the other half were disconfirmative (disagree or strongly disagree- (on euthanasia and physician assisted suicide) with one remaining of don't know.

The sample (questions) dealt with a variety of issues surrounding euthanasia and physician assisted suicide, for example, the extending technology, legal issues, quality of life, and attitudes and beliefs about themselves and others regarding cessation of pain and suffering.

The subjects consisted of college students from Sociology classes from two universities in the Atlanta area. The dependent variable attitudes and beliefs about euthanasia and physician assisted suicide was based on the

three independent variables race, age, and gender. The response rate was 100% (n=116) of the administered questionnaire. The students were advised that they did not have to participate in this study.

When studying euthanasia and physician assisted suicide and the attitudes and beliefs among college age students based on their race, age, and gender we have seen how these variables do come into play. The test statistics for race, age, and gender were measured by chi-square.

What was found is that Whites more than any other racial group studied, were in favor of the legalization of euthanasia and physician assisted suicide. Seventeen to twenty-six year olds feel that euthanasia and physician assisted suicide should be made legal and that if they were faced with a terminal illness they would want to be able to end their life in the easiest and fastest way possible. And females more than males are in favor of euthanasia and physician assisted suicide.

Race had a chi-square of 86.843 with 3 df (16.268) was statistically significant at the point (<.001) level between the relationship of attitudes and beliefs and race.

Age had a chi-square of 51.922 with 3 df (16.268) was statistically significant at the point (<.001) level

which showed a relationship between attitudes and beliefs and age.

Gender had a chi-square of 44.690 with 1 df (10.827) was statistically significant at the point (<.001) level showing a relationship between attitudes and beliefs and gender.

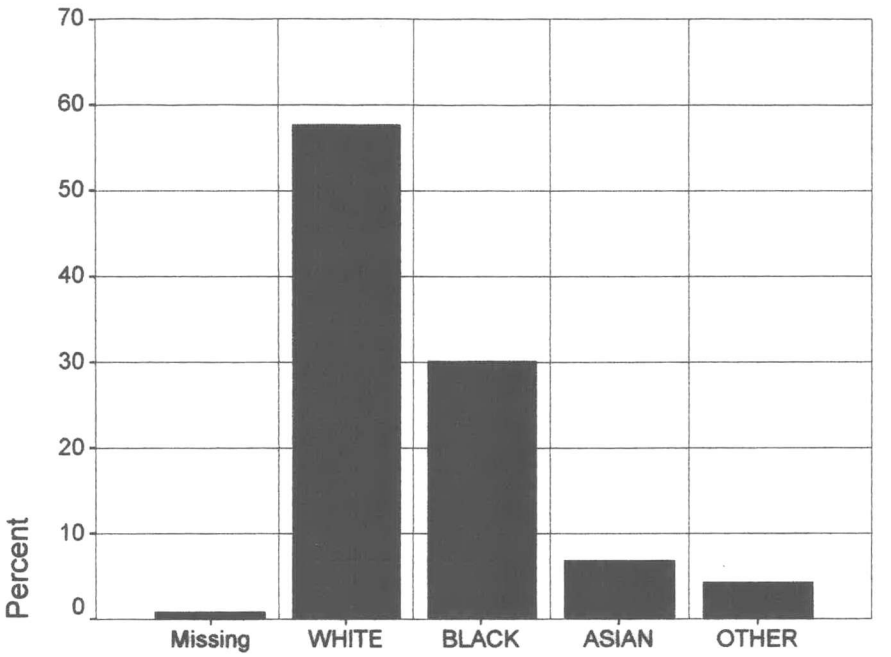


Figure 1. Race.

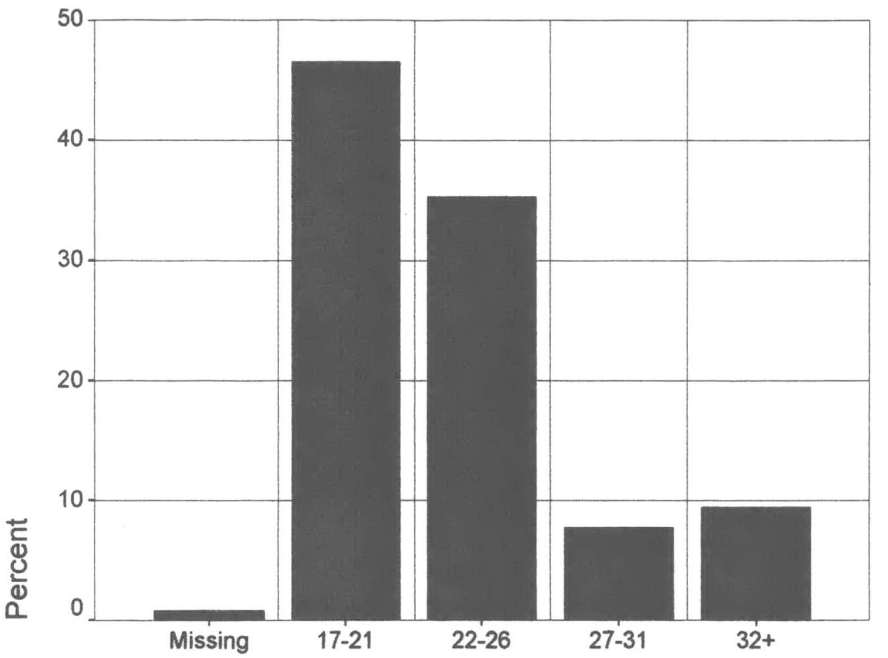


Figure 2. Age.

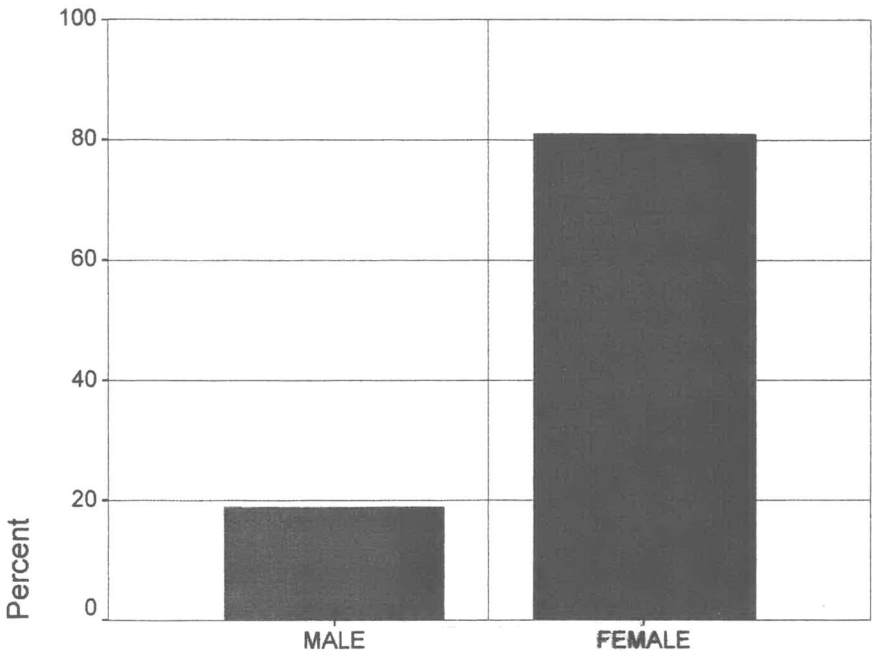


Figure 3. Gender.

## CHAPTER SEVEN

## DISCUSSION

This study has investigated the relationship between attitudes and beliefs among college age students on euthanasia and physician assisted suicide. The results indicated that race, age, and gender do effect attitudes and beliefs and how these young people think and feel about the legalization of euthanasia and physician assisted suicide. Also, how they think and feel if they were faced with that decision in their own lives.

The majority of the respondents in this study tended to:

1. Approve of euthanasia and physician assisted suicide;
2. Prefer to have that option if faced with a terminal illness; and
3. That it should be made legal and physicians should be able to help and assist their patients without facing legal consequences.

The response rate to the questionnaire (100%) was relatively high, but this rate was certainly not influenced by the researcher. The students were informed that they did not have to participate in this study. The representation of certain groups was high, but shows the direction in which

our future is moving. For example, there were more female respondents than male respondents, 94 and 22 respectively. Also, there were more 17-21 year old students and 22-26 year old students 54 and 41 versus 27-31 and 32+ with 9 and 11 respectively for each category. Race differences were Whites, Blacks, Asian, and other 67, 35, 8, and 5 respectively.

Realizing some of the observed numbers were higher for some categories, and this study still has shown that race, age, and gender do effect attitudes and beliefs concerning euthanasia and physician assisted suicide.

Although college students are a nonrepresented sample of the total population, they do represent the population of the next generation of law and policy makers.

It has been found that the majority of these students favor laws to allow euthanasia and physician assisted suicide. And if they were faced with a terminal illness they should have a legal right to have their pain and suffering ended in the fastest and easiest way possible, and physicians and the law should honor this request.

With wide public interest in euthanasia and physician assisted suicide, physicians and the courts should work to improve the care and requests of the terminally ill patient. These efforts should include better communication

with patients, acknowledge advance directives, and honor requests concerning "do not resuscitate."

Euthanasia and physician assisted suicide has become and will continue to be a serious issue in our society. Therefore, as this study has shown the attitudes and beliefs of college age students are significant and important as they see that euthanasia and physician assisted suicide should be legal and that they themselves would choose to do so if faced with a terminal illness.

Unfortunately, this is such a controversial issue that it will take this next generation to change and improve the laws and policies concerning euthanasia and physician assisted suicide.

Future research on euthanasia and physician assisted suicide by sociologists is needed.

## APPENDIX ONE

## QUESTIONNAIRE

Euthanasia is defined as acting to terminate or failing to act in such a way as to extend the life of persons who are hopelessly sick or injured for reasons of mercy (Holloway et al.). Physician assistance with suicide occurs when physicians use their medical knowledge to assist patients with death (Waun).

1. What is your race?

   White- Black- Asian- Other-

2. What age group are you in?

   (17-21)-
   (22-26)-
   (27-31)-

3. What is your gender (sex)?

   Male- Female-

4. Attitudes about euthanasia and physician assisted suicide for the terminally ill.

Q. To me there is absolutely no justification for ending the lives of persons even though they are terminally ill.

   1. Strongly Agree-
   2. Agree-
   3. Disagree-
   4. Strongly Disagree-
   5. Don't Know

Read each statement carefully; select one of five possible responses where 1 is Strongly Agree to 5 Don't Know. Choose the response that most closely represents your own attitude toward these statements.

5. A terminally ill individual should be allowed to reject life support systems.

   1. Strongly Agree-
   2. Agree-
   3. Disagree-
   4. Strongly Disagree-
   5. Don't Know

6. It is cruel to prolong intense suffering for someone who is morally ill and desires to die.

   1. Strongly Agree-
   2. Agree-
   3. Disagree-
   4. Strongly Disagree-
   5. Don't Know

7. The termination of a person's life, done as an act of mercy, is unacceptable to me.

   1. Strongly Agree-
   2. Agree-
   3. Disagree-
   4. Strongly Disagree-
   5. Don't Know

8. One should have the right to choose to die if he/she is terminally ill and is suffering.

   1. Strongly Agree-
   2. Agree-
   3. Disagree-
   4. Strongly Disagree-
   5. Don't Know

9. I believe it is more humane to take the life of an individual who is terminally ill and in severe pain than to allow him/her to suffer.

   1. Strongly Agree-
   2. Agree-
   3. Disagree-

4. Strongly Disagree-
5. Don't Know

10. Under any circumstances I believe that physicians should try to prolong the lives of their patients.

1. Strongly Agree-
2. Agree-
3. Disagree-
4. Strongly Disagree-
5. Don't Know

11. I believe there should be legal avenues by which an individual could pre-authorize his/her own death in case intolerable illnesses arise.

1. Strongly Agree-
2. Agree-
3. Disagree-
4. Strongly Disagree-
5. Don't Know

12. I bear no ill feelings toward a person who hastens the death of a loved one to spare the loved one further unbearable physical pain.

1. Strongly Agree-
2. Agree-
3. Disagree-
4. Strongly Disagree-
5. Don't Know

13. Do you approve of "Right to Die" legislation which allows medical treatment for the terminally ill patient to be withdrawn or withheld, if that is what the patient wishes?

1. Strongly Agree-
2. Agree-
3. Disagree-
4. Strongly Disagree-
5. Don't Know

14. There are circumstances in which a person should be allowed to die.

1. Strongly Agree-
2. Agree-

3. Disagree-
4. Strongly Disagree-
5. Don't Know

15. There should be laws allowing patients to request and have honored, physician assisted suicide or euthanasia.

1. Strongly Agree-
2. Agree-
3. Disagree-
4. Strongly Disagree-
5. Don't Know

16. I would consider physician assisted suicide or euthanasia if terminally ill.

1. Strongly Agree-
2. Agree-
3. Disagree-
4. Strongly Disagree-
5. Don't Know

17. There should be a specified waiting period between when a patient requests a drug overdose to end his/her life and when such a request is granted.

1. Strongly Agree-
2. Agree-
3. Disagree-
4. Strongly Disagree-
5. Don't Know

18. Does a person have the right to actively terminate his/her own life?

1. Strongly Agree-
2. Agree-
3. Disagree-
4. Strongly Disagree-
5. Don't Know

19. A terminally ill person who is in severe pain deserves the right to have his/her life ended in the easiest way possible.

1. Strongly Agree-
2. Agree-
3. Disagree-

4. Strongly Disagree-
5. Don't Know

20. If I were faced with the situation of suffering a slow and painful death, I should have the right to choose to end my life in the fastest and easiest way possible.

1. Strongly Agree-
2. Agree-
3. Disagree-
4. Strongly Disagree-
5. Don't Know

Thank you for your time in filling out this questionnaire.

## APPENDIX TWO

## CODE BOOK FOR QUESTIONNAIRE

4. AEPAST - Attitudes about euthanasia and physician assisted suicide for the terminally ill.

5. TIRLSS - A terminally ill individual should be allowed to reject life support systems.

6. CPISMID - It is cruel to prolong intense suffering for someone who is mortally ill and desires to die.

7. TPLAMUN - The termination of a person's life, done as an act of mercy, is unacceptable to me.

8. OHRCDTS - One should have the right to choose to die if he/she is terminally ill and is suffering.

9. BHLITSPS - I believe it is more humane to take the life of an individual who is terminally ill and in severe pain than to allow him/her to suffer.

10. UCBPTPLP - Under any circumstances I believe that physicians should try to prolong the lives of their patients.

11. BLIPODII - I believe there should be legal avenues by which an individual could pre-authorize his/her own death in case intolerable illnesses arise.

12. BNIFHDUP - I bear no ill feelings toward a person who hastens the death of a loved one to spare the loved one further unbearable physical pain.

13. ARDATPWW - Do you approve of "right to die" legislation which allows medical treatment for the terminally ill patient to be withdrawn or withheld, if that is what the patient wishes?

14. ACPSAD - There are circumstances in which a person should be allowed to die.

15. LAPRPASE - There should be laws allowing patients to request and have honored, physician assisted suicide or euthanasia.

16. WCPASETI - I would consider physician assisted suicide or euthanasia if terminally ill.

17. SSWPPROG - There should be a specified waiting period between when a patient requests a drug overdose to end his/her life and when such a request is granted.

18. DPRATOL - Does a person have the right to actively terminate his/her own life?

19. TPSPREEP - A terminally ill person who is in severe pain deserves the right to have his/her life ended in the easiest way possible.

20. IFSPDREL - If I were faced with the situation of suffering a slow and painful death, I should have the right to choose to end my life in the fastest and easier way possible.

SA - Strongly Agree

A -Agree

D - Disagree

SD - Strongly Disagree

DK - Don't Know

## APPENDIX THREE

## RESULTS FROM QUESTIONNAIRE

The first independent variable dealt with race and attitudes toward euthanasia and physician assisted suicide. The categories were as follows: Whites 67 (57.8%), Blacks 35 (30.2%), Asian 8 (6.9%), those who classified themselves as other 5 (4.3%) with a total of 115 (99.1%). With one case missing (.99%). The Question under (attitudes about euthanasia and physician assisted suicide for the terminally ill): to me there is absolutely no justification for ending the lives of persons even though they are terminally ill. For strongly agree the frequency was 11 (9.5%), agree 11 (14.7%), disagree 57 (49.1%), strongly disagree 20 (17.2%), and don't know 10 (8.6%) for a total of 115 (99.1%) with 1 missing case (.99%). Breaking this down even further the numbers are as follows: Whites (3), Blacks (6), Asian (1), and other (1), total = 11 for strongly agree. For agree, Whites (6), Blacks (9), Asian (2), and other (0), total = 17. Category disagree, Whites (39), Blacks (13), Asian (3), and (2) other with total = 57. Then for strongly disagree (15) Whites, (5) Blacks, (0) Asian, (0) other,

total = 20. Don't know, (4) Whites, (1) Black, (2) Asian, (2) other, total = 9. For a complete total = 114 with N missing 2.

For the question: under any circumstances I believe that physicians should try to prolong the lives of their patients. The breakdown again is as follows for race. The percentages have already been mentioned for each category. The responses for each race are, (0) Whites, (8) Blacks, (0) Asian, (0) other for strongly agree. Agree, (11) Whites, (7) Blacks, (1) Asian, and (0) for other. Disagree, (38) Whites, (11) Blacks, (2) Asian, (2) other. Strongly disagree, (13) Whites, (3) Blacks, (1) Asian, (1) other. Don't know, (5) Whites, (5) Blacks, (1) Asian, (2) other. N=114 with 2 missing cases.

When asked the question, I would consider physician assisted suicide or euthanasia if terminally ill. Whites indicated 13 strongly agree, 30 agree, 10 disagree, 3 strongly disagree, and 11 don't know. Blacks, 4 strongly agree, 4 agree, 4 disagree, 11 strongly disagree, 12 don't know.

For the sake of the results, SA will be strongly agree, A-Agree, D-Disagree, SD-strongly disagree, DK-don't know.

Asians, 2-SA, 0-A, 1-D, 2-SD, 3-DK. Other, 0-SA, 2-A, 1-D, 0-SD, 2-DK. Total-115 with one missing case.

The next question: Do you approve of "Right to Die" legislation which allows medical treatment for the terminally ill patient to be withdrawn or withheld, if that is what the patient wishes? Whites - 26-SA, 34-A, 1-D, 1-SD, 5-DK. Blacks - 9-SA, 13-A, 4-D, 2-SD, 7-DK. Asians - 2-SA, 5-A, 1-D, O-SD, 0-DK. Other - 1-SA, 3-A, 0-D, 0- SD, 1-DK.

There should be a specified waiting period between when a patient requests a drug overdose to end his/her life and when such a request is granted. The results showed that Whites answered: 6-SA, 44-A, 4-D, 3-SD, 10-DK. Blacks - 3-SA, 15-A, 4-D, 2-SD, 10-DK. Asians - 1-SA, 4-A, 1-D, 0-SD, 2-DK. Other - 0-SA, 2-A, 2-D, 0-SD, 1-DK.

Next question stated: A terminally ill individual should be allowed to reject life support systems. Whites - 39-SA, 26-A, 1-D, 1-SD, 0-DK. Blacks - 16-SA, 18-A, 0-D, 0-SD, 1-DK. Asians - 2-SA, 1-A, 3-D, 0-SD, 2-DK. Other - 2-SA, 3-A, 0-D, 0-SD, 0-DK.

When asked: There should be laws allowing patients to request and have honored, physician assisted suicide or euthanasia. Whites - 19-SA, 35-A, 6-D, 2-SD, 5-DK. Blacks

- 7-SA, 13-A, 7-D, 3-SD, 5-DK. Asians - 2-SA, 4-A, 2-D, 0-SD, 0-DK. Other - 0-SA, 1-A, 1-D, 0-SD, 3-DK.

If I were faced with the situation of suffering a slow and painful death, I should have the right to choose to end my life the fastest and easiest way possible. Whites - 30-SA, 27-A, 6-D, 1-SD, 3-DK. Blacks - 11-SA, 5-A, 5-D, 5-SD, 8-DK. Asians - 1-SA, 5-A, 0-D, 0-SD, 2-DK. Other - 1-SA, 3-A, 0-D, 0-SD, 1-DK.

Although all the questions asked were very important to the study, these particular questions were felt to be the most pertinent in the study that looked at attitudes and beliefs.

The next set are the same questions asked according to race (Figure 1), they will now be asked according to the respondents age (Figure 2, and Appendix Two) which is the second independent variable. They will be asked (see Figure 1) by their code throughout the rest of the results being shown.

AEPAST - 17-21: 4-SA, 10-A, 30-D, 6-SD, 4-DK. 22-26: 4-SA, 7-A, 18-D, 8-SD, 3-DK. 27-31: 1-SA, 0-A, 3-D, 4-SD, 1-DK. 32+: 2-SA, 0-A, 6-D, 2-SD, 1-DK.

UCBPTPLP - 17-21: 4-SA, 11-A, 26-D, 4-SD, 9-DK. 22-26: 4-SA, 6-A, 18-D, 6-SD, 6-DK. 27-31: 0-SA, 1-A, 4-D, 6-SD, 6-DK. 32+: 0-SA, 1-A, 6-D, 4-SD, 0-DK.

WCPASETI - 17-21: 5-SA, 18-A, 7-D, 11-SD, 13-DK. 22-26: 5-SA, 13-A, 8-D, 3- SD, 12-DK. 27-31: 4-SA, 3-A, 0-D, 1-SD, 1-DK. 32+: 5-SA, 2-A, 1-D, 1-SD, 2-DK.

ARDATPWW - 17-21: 13-SA, 30-A, 3-D, 2-SD, 6-DK. 22-26: 12-SA, 19-A, 3-D, 0-SD, 7-DK. 27-31: 7-SA, 2-A, 0-D, 0-SD, 0-DK. 32+: 7-SA, 3-A, 0-D, 1-SD, 0-DK.

SSWPPROG - 17-21: 7-SA, 29-A, 7-D, 1-SD, 9-DK. 22-26: 1-SA, 23-A, 5-D, 0-SD, 12-DK. 27-31: 1-SA, 5-A, 0-D, 2-SD, 1-DK. 32+: 1-SA, 8-A, 0-D, 2-SD, 0-DK.

TIRLSS - 17-21: 25-SA, 25-A, 3-D, 1-SD, 0-DK. 22-26: 19-SA, 18-A, 1-D, 0-SD, 3-DK. 27-31: 6-SA, 3-A, 0-D, 0-SD, 0-DK. 32+: 10-SA, 1-A, 0-D, 0-SD, 0-DK.

LAPRPASE - 17-21: 7-SA, 29-A, 8-D, 4-SD, 6-DK. 22-26: 9-SA, 20-A, 7-D, 1-SD, 6-DK. 27-31: 7-SA, 0-A, 0-D, 0-SD, 2-DK. 32+: 6-SA, 4-A, 1-D, 0-SD, 0-DK.

IFSPDREL - 17-21: 18-SA, 23-A, 4-D, 4-SD, 3-DK. 22-26: 14-SA, 13-A, 4-D, 1-SD, 9-DK. 27-31: 6-SA, 1-A, 1-D, 0-SD, 1-DK. 32+: 6-SA, 3-A, 1-D, 1-SD, 0-DK.

The frequency of each age group along with their percentages: 17-21: 54 (46.6%), 22-26: 41 (35.3%), 27-31: 9 (7.8%), 32+: 11 (9.5%) total = 115 (99.1%) with 1 case missing (.99%).

The third independent variable gender (see Figure 3) had frequencies and percentages in this way: Males: 22 (19.0%) and Females: 94 (81.0%).

AEPAST - Males: 2-SA, 4-A, 9-D, 4-SD, 3-DK. Females: 9-SA, 13-A, 48-D, 16-SD, 7-DK.

UCBPTPLP - Males: 2-SA, 1-A, 9-D, 3-SD, 7-DK. Females: 6-SA, 18-A, 45-D, 15-SD, 9-DK.

WCPASETI - Males: 4-SA, 6-A, 3-D, 4-SD, 5-DK. Females: 15-SA, 30-A, 13-D, 12-SD, 24-DK.

ARDATPWW - Males: 10-SA, 8-A, 0-D, 0-SD, 4-DK. Females: 29-SA, 47-A, 6-D, 3-SD, 9-DK.

SSWPPROG - Males: 1-SA, 11-A, 4-D, 0-SD, 6-DK. Females: 9-SA, 54-A, 8-D, 5-SD, 17-DK.

TIRLSS - Males: 13-SA, 7-A, 1-D, 0-SD, 1-DK. Females: 47-SA, 41-A, 3-D, 1-SD, 2-DK.

LAPRPASE - Males: 6-SA, 9-A, 4-D, 1-SD, 2-DK. Females: 23-SA, 44-A, 12-D, 4-SD, 11-DK.

IFSPDREL - Males: 12-SA, 6-A, 1-D, 0-SD, 3-DK. Females: 32-SA, 34-A, 10-D, 6-SD, 11-DK.

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